MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC

CLIENT REGISTRATION

Makrinos Mental Health Counseling Services, LLC must verify the identity and authority of Client or a personal representative (a copy of valid photo ID or Driver's License may be requested)

PERSONAL INFORMATION		Date:
Name:		Gender (Check One): ○ Male ○ Female ○ Other
Birthdate:		Social Security #:
Address:		
City:	State:	Zip Code:
Home Phone#:	Cell Phone#:	Work Phone#:
Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No
Personal Email:		
Primary Care Physician:		Physician Phone#
Primary Care Physician Address:		
Employer Name:		
Employer Address:		

INSURANCE INFORMATION	
Primary Insurance Name:	Secondary Insurance Name:
Primary Insurance ID#	Secondary Insurance ID#

PRIMARY POLICYHOLDER INFORMATION *(If different than Client)*		
Name:		Gender (Circle One): Male / Female / Other
Birthdate:		Social Security #:
Address:		
City:	State:	Zip Code:
Home Phone#:	Cell Phone#:	Work Phone#:
Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No
Employer Name:		
Employer Address:		

SECONDARY POLICYHOLDER INFORMATION *(If different than Client)*		
Name:		Gender (Circle One): Male / Female / Other
Birthdate:		Social Security #:
Address:		
City:	State:	Zip Code:
Home Phone#:	Cell Phone#:	Work Phone#:
Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No
Employer Name:		
Employer Address:		

RESPONSIBLE PARTY INFORMATION *(If not the Client or Policyholder)*		
Name:		Gender (Circle One): Male / Female / Other
Birthdate:		Social Security #:
Address:		
City:	State: OH	Zip Code:
Home Phone#:	Cell Phone#:	Work Phone#:
Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No	Leave Message: ❑ Yes ❑ No
Employer Name:		
Employer Address:		

EMERGENCY CONTACT		
Name:		Relationship
Home Phone#:	Cell Phone#:	Work Phone#: